PRIOR AUTHORIZATION GENERAL REQUEST FORM

Prescribing Physician:
Name (First, Last)
Direct Phone #
Fax #
Physician specialty

Patient:	
Name (First, Last)	
ID #	Sex (at birth): ❑ M ❑ F
Phone #	Client
Birth Date: ___/___/___	Age

Name and title of person completing form (please print):			
1. Drug name:	2. Dose/Strength:	3. Frequency:	4. Duration:
5. Diagnosis:		6. ICD code:	

7. Has patient been on this drug? ❑Yes ❑No If yes, for how long: _____

8. Has the patient been seen by any other provider for this condition? ❑Yes ❑No
If yes, which specialty? _____

9. What are the previous medications that were tried and failed in the past for this diagnosis:

Drug name	Reason for failure	Dates
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___

10. Please indicate pertinent laboratory tests or procedures for this diagnosis:

Procedure/Lab:	Findings:	Date:

Physician's Name (print): _____ Title: _____

Physician's Signature: _____Date: ___/___/_____

Fax PA request form AND Supporting Documentation to: SGRX @ 313-264-0985